PRINTED: 10/03/2008

EMENT OF DEFI	SIENGIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	COMPL	ETEO
PLAN OF CORRE	CTION	IDENTIFICATION NUMBER:	A BUILD	<del></del> -		
		09G151	B. WING			9/2008
ME OF PROVIDER	OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP COL 1600 FRANKLIN STREET, NE	)E	
HOLISTIC 08				WASHINGTON, DC 20017 PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
X4) ID (E. REFIX RE	요ㅡㅡ;이트니스	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	- AARDEOTNE ACTION	SHOULD BE	COMPLETION
N 000 INITIA	IL COMMEN	ıтs	W D	00		
Septe 2008. funds of two four four four four four four four fou	mber 17, 20 The survey mental surve o clients were emales with indings of the reat, interview orogram and inistrative ince ant and inve- 420(a)(3) PR ITS facility must refore, the fa- idual clients o facility and	arvey was conducted from 108 through September 19, was initiated using the ey process. A random sample re selected from a population of various disabilities.  is survey were based on the group home and one day was at both the group home and review of clinical and cluding the facility's unusual stigation reports.  COTECTION OF CLIENTS  ansure the rights of all clients. clirty must allow and encourage to exercise their rights as clients of as citizens of the United States, at to file complaints, and the right	w ·	GOVERNMENT OF THE DIST DEPARTMENT OF HEALTH REGULATION A 825 NORTH CAPITOL ST. WASHINGTON, D	HEALTH THEALTH DMINISTRATION, N.E., 2ND FLO	ON
Bas Qua (QM den prot indi of ti for The	ed on observabled Mental IRP) and reconstrate howested and favidual clients of 4 clients of 5 cl	D is not met as evidenced by: vation, interviews with the l Retardation Professional cord review, the facility failed to w the rights of all clients were alled to allow and encourage to exercise their rights as clients and as citizens of the United States i residing in the facility.  uides: d to ensure clients' rights were aking certain each client had a				

Any deficiency extendent ending with an extensit (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-99) Previous Versions Obsoleta

Event ID: LZVC11

Facility ID: 09G151

If continuation sheet Page 1 of 9

EPARTM	ENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES		·		OMB NO.	
ENTERS	DEFICIENCIES		1.		CONSTRUCTION	COMPLET	ED
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	•	09G151	B. WII				/2008
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٠ ١.	Continued From p	representative to assist them ions residential placement as			Quirp shall in Arm i	n writing	
	Avidenced pelow: Nith waking decis	Ons tesidential place.	l 		the use of the Ala	eima	10/11/01
1	During the SUIVEY	conducted from September	}		Caurelians, will be	2.101	, 100
	47 48 988E 8 88	VL 313LW ASS HORSE IS GALLE	ļ		an approximate to ar	ticulare	
1	i mammatan katan dalah dara	erior door to the facility opened. Qualified Mental Retardation	1		concerns and any	ppos: Ham	
	Destactant /OM	IBB) WY SODIBLIDAL 12' TAAA O'		İ	shall be taken that	web the	
1	vimately 7:4	45 PM revealed the purpose of as to address Client #4's target		1	SHAR DE RAPER TITL		
	しょしゃいしゃ みず かしのわさ	ment The UMKF UILIE GREET			HRE for a dignity	VS. RISK	
	that the use of the by the Human Ri	e door glarm had been approved ghts Committee (HRC). Review tes dated May 8, 2008 on 1008 at 2:35 PM confirmed the	1		analysis.		
	Continued interv Client #4's house they all approved and/or by implici revealed that Cli- guardians and/or not involved in the regarding the do Review of Client	elew with the QMRP revealed that emates were informed of the and deither by verbal response ation. The QMRP further tent #4's housemates legal or involved family members were he decision making process for alarm.  If #4's housemates psychology dicated that they did not evidence.					
W 159	the capacity to a their behalf regular placement, treat matters.	make independent decisions on arding habilitation planning, atment, financial or medical ALIFIED MENTAL N PROFESSIONAL		W 15	9		
	Each client's at integrated, coo qualified ments	etive treatment program must be indinated and monitored by a giretardation professional.			Fealtity ID: 08G181	if continuation	sheet Page (

PRINTED: 10/03/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09/19/2008 09G151 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1800 FRANKLIN STREET, NE WASHINGTON, DC 20017 WHOLISTIC 08 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PREFIX TAG W 158 W 159 Continued From page 2 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: See wi25 1. The QMRP failed to ensure how the rights of all clients were protected and failed to allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States. [See W125] 2. The QMRP falled to ensure that fire see 440 evaluation drills were conducted quarterly on all shifts. [See 440] W 325 482.460(a)(3)(iii) PHYSICIAN SERVICES W 325 The facility must provide or obtain annual physical examinations of each client that at a minimum Includes routine screening laboratory

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sample, (Client #1)

The finding includes:

physician.

examinations as determined necessary by the

This STANDARD is not met as evidenced by:

Based on observation, interview, and record
review, the facility falled to provide routine

laboratory testing as determined necessary by the physician for one of two clients included in the

On September 17, 2008 at 6:49 PM, Client #1

Event ID: LZVC11

Facility (D: 09G151

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PRINTED: 10/03/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING B, WING 09/19/2008 09G151 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 FRANKLIN STREET, NE WHOLISTIC 08 WASHINGTON, DC 20017 PROVIDER'S PLAN OF CORRECTION (X8) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG W 325 Continued From page 3 W 325 was administered Lithium Carbonate 300 mg by RN will ensure that all mouth. Interview with the Trained Medication 1916/01 Employee (TME) revealed that the medication abs are secured as was prescribed for maledaptive behaviors. prescribed in POS. Review of Client #1's Physician's Orders (POS) dated September 2008 on September 18, 2008 at Nursels monthlies shall 1;18 PM revealed an order for the client to receive Lithium levels every 2-3 months. Review address Labs and whether of the laboratory tests on September 18, 2008 at approximately 1:18 PM revealed Client #1 or Nor they have been received labs in July 2008, May 2008, and attained. Quartery RN December 2007. Further record review and notes shall review monthly interview with the facility's Licensed Practical Nurse Coordinator (LPN) on the same day at 1:55 holes to ensury completeon PM acknowledged that Cilent # 1's Lithium levels of Labs as required were not obtained as recommended by the physician. W 331 W 331 483,460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by. Based on interviews and record review, the facility's nursing services falled to ensure that each client received nursing services in See W325 accordance with their needs for one of two clients included in the sample. (Client #1) The finding includes: The facility's nursing staff failed to ensure routine laboratory tests were obtained in accordance with physican's orders for Client #1. [See W325] 483.460(g)(2) COMPREHENSIVE DENTAL W 356 W 356 TREATMENT

The facility must ensure comprehensive dental

PRINTED: 10/03/2008 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 093<u>8-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A BUILDING 09/19/2008 B. WING 09G151 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 FRANKLIN STREET, NÉ WASHINGTON, DC 20017 WHOLISTIC 08 PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD SE
CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X4) ID TAG PRÉFIX DEFICIENCY) TAG W 356 W 356 | Continued From page 4 treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on Interview and record review, the facility falled to ensure timely dental services, for two of two clients included in the sample. (Client #1 and Dental Services had been #2) Challenging to Schedule. However, quite recently The findings includes: 10/01/01 1. On September 17, 2008 during evening observations, Client #1 was observed with some getting appointments have improved substantially. discoloration on her teeth. Review of Client #1's medical records on September 18, 2008 at approximately 2:10 PM revealed a dental consult dated September 13, 2007. According to the The october on appointment consult, Client #1 was scheduled for dental treatment, but refused to get off the van and therefore, the appointment was rescheduled. has been completed. In Interview with the Licensed Practical Nurse (LPN) the Future Any delays coordinator revealed that Client #1 had a dental appointment scheduled for October 6, 2008 over in securing appointments a year later. Interview with the facility's Registered Nurse (RN) on September 15, 2008 at approximately 2:19 PM revealed that Client #1 should have been scheduled for her six month dental treatment prior to the October 2008 appointment. There was no evidence that any recommend atoms shall other attempts to obtain dental services for Client be transcribed in the #1 prior to October 2008. Nurses monthly and

On September 17, 2008 during evening observations, Client #2 was observed with plaque

bulld up on her teeth. Review of Client #2's

medical records on September 18, 2008 at

implementation

in the record.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2005 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		09G151	B. WIN	G		09/11	9/2008
NAME OF P	rovider or supplier TIC 08			160	ET ADDRESS, CITY, STATE, ZIP CODE O FRANKLIN STREET, NE USHINGTON, DC 20017	_	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION 6HI CROSS-REFERENCED TO THE APP DEFICIENCY)	CULD BE	COMPLETION DATE
W 356	approximately 3:15 dated July 30, 200 consultant's notes, periodontal disease calculus on all teet recommended that for full mouth scaling surfaces in six more coordinator on Sepapproximately 3:36 had a scheduled diseasember 24, 200 time of the survey, evidence that Client services.  483.460(k)(4) DRUTHE system for druthet clients are tau medications if the determines that set is an appropriate of does not specify of this STANDARD Based on observatively of records, an effective system participated in a set for two of two clients.	AM revealed a dental consul 7. According to the the client had advanced 8 and deposits of plaque h surfaces. The dentist 1. Client #2 return to the office hig and polishing of all teeth hits. Interview with the LPN hitember 18, 2008 at 8 PM revealed that Client #2 ental appointment on hit (over a year later). At the the facility falled to provide hit #2 received timely dental  JG ADMINISTRATION  Alig administration must assure ght to administer their own interdisciplinary team hit-administration of medications hip-administration of medications	w	371			
	(Client #1 and #2) The findings include  4. On Service has	de:					
	was administered Chlorpromazine H	17, 2006 at 6:49 PM, Client #1 Lithium Carbonate 300 mg and ICL 50 mg by mouth by the n Employee (TME) during the					

		AND HUMAN SERVICES		Fo	TED: 10/03/2008 DRM APPROVED NO. 0938-0391			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	FIPLE CONSTRUCTION (X3) DA	ATE SURVEY OMPLETED			
		09@151	B. WING	<del></del>	09/19/2008			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 FRANKLIN STREET, NE WASHINGTON, DC 20017					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X3) COMPLETION E DATE			
W 371	observed to retrieve and poured water is observations reveal medications into the medications to Clie consumed her medications to Clie consumed her medications with the fron September 19, 20 PM revealed that Classessment dated have a self-medical Review of the self-september 18, 200 recommended to program. There will had been identified	n administration. Client #1 was e a cup from the dishwasher nto the cup. Further lied the TME punched a pill cup and explained the int #1. Client #1 independently dications and placed the cup	W 371	Self-mediowhon program client #115 INF place.	10/16/08			
	was administered and appending medical explained to Client punched medication and poured water is observed to drink inconsumed the medical interview with the fron September 18, 2 PM revealed that C	17, 2008, at 7:00 PM, Client #2 Amantedine HCL, 100 mg and g by mouth by the TME during ation administration. The TME #2 what she was taking, ins into the medication cup, in the cup. Client #2 was ier cup water as she ilications.  acility's Registered Nurse (RN) 2008, at approximately 2:00 illent #2 had a self-medication thoughts to the proximately acident in the proxim		Self-Mediature program.  Client the 2 is in place	for ululog			

programs established. Review of the

self-medication assessment dated June 12, 2008, and further interview with the RN revealed that Client #2 was recommended to participate in a

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/03/2008 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(XS) DATE SURVEY COMPLETED	
		09G151	B. WI	NG_		09/1	9/2008
NAME OF P	ROVIDER OR SUPPLIER TIC 08			16	EET ADDRESS, CITY, STATE, ZIP CODE 100 FRANKLIN STREET, NE (ASHINGTON, DC 20017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREF TAG		FROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD RE	()(5) COMPLETION DATE
W 440	that a program had Client #2 in the don administration.  483,470(i)(1) EVAC The facility must he quarterly for each a This STANDARD is Based on staff interfacility failed to hold all shifts.  The finding include Interview with the Certification of September on Sept	gram. There was no evidence been identified/established for nain self-medication  CUATION DRILLS  old evacuation drills at least shift of personnel.  Is not met as evidenced by: rylew and record review, the devacuation drills quarterly on s:  Qualified Mental Retardation  P) and review of the staffing ber 18, 2008 at 11:56 AM used shifts were as follows:  ands  PM 2 AM	W		Staff the be retained on fire Drivi schedule and their role in it implementation. Problems issued repriment to House Manager for to implement the regular she has been true multiple times. The the lest time this rise Will recione this cite	ale.  Involve  Actions  Actions  Telling  Tilling	10/14/08
	conducted during e	fire drills had not been each shift. There was no irills were conducted quarterly					

PRINTED: 10/03/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OME NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G151 09/19/200B NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1500 FRANKLIN STREET, NE WHOLISTIC 08 WASHINGTON, DC 20017 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG (XS) COMPLETION DATE (X4) ID PREFIX TAG W 440 Continued From page 8 W 440 on all shifts. This is a repeated, uncorrected deficiency. See deficiency report dated August 22, 2007.

FORM CMS-2557(02-89) Previous Versions Obsoleta

Event ID: LZVC11

Facility ID: 09G181

If continuation sheet Page 9 of 9

Health F	<u>Regulation Administrations and Administration (Control of Control /u>	<u> ation</u>					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(XX) MULT A. BUILDIN B. WING	IFLE CONSTRUCTION	(XS) DATE SUR COMPLETE	iD
NAME OF F	PRÓVIDER OR SUPPLIER	HFD03-0172	QTDEET AD	DDESS CITY	STATE, 2IP CODE	09/19/2	500R
WHOLIS			1600 FRA	NKLIN STR STON, DC 2	REET, NE	ı	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY)			
	September 17, 200 2008. The survey of two clients were four females with vote of two clients were four females with vote of two clients were four females with vote of two clients at the program, interviewed day program, reviewed and investigation resords to include the and investigation resords and investigation recontract worker for in all jurisdictions were or contract worker for in all jurisdictions were check.  This Statute is not based on the intendictions where	was conducted from 18 through September was initiated using the process. A random selected from a populations disabilities. It survey were based to group home, one day at both the group her of clinical and admitted facility's unusual	or 19, en sample substitution of an and sinistrative incident sclose the coyee or (7) years, sective dor to the cords, the pround in all resided	R 000	Received to 18 18 GOVERNMENT OF THE DISTRICT DEPARTMENT OF THE HEALTH REGULATION ADN 825 NORTH CAPITOL ST., N.I. WASHINGTON, D.C.  Some of The Five Straff that are in question and the free with	EALTH IINISTRATION E., 2ND FLOOR 20002  com players wholeste	oliyos
-	Professional and re September 19, 200 GHMRP falled to p background checks listing of all jurisdic	es:  Qualified Mental Reta sview of the personne 08 et 12:32 PM reves rovide evidence of a s that disclosed a sections where five (5) a	el files on led the criminal ven year		prior to the implement of this requirement these implea this prospectively. Tremaining were compound to the facility. All st	t. rented te	
	latton Administration  Wetter Theory  Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESE/	NTATIVE'S SIG		Resident TITLE	10/14	DATE

<u>Health R</u>	legulation Administra	tion								
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	A, BUILDIN	G	TRUCTION		(X3	DATE SU COMPLE	
1		HFD03-0172		B. WING _					09/19	/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	REET ADDRESS, CITY, STATE, ZIP CODE						
WHOLIS	TIC 08		1600 FRAI WASHING	NKLIN STR TON, DC 2	EET, NE 0017					
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	persons had worked or resided at the time of the survey.				seen			n place		10/17/08
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Health Re	egulation Administr	atlon	<u>-</u>				
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULT A. BUILDIN B. WING _		(X3) DATE SU COMPLET	
NAME OF BE	OVIDER OR SUPPLIER		STREET ADD	DRESS, CITY.	STATE, ZIP CODE	<u> </u>	
WHOLIST	1		1600 FRA	NKLIN STR TON, DC 2	EET, NE		
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1 000	INITIAL COMMEN	тѕ		1 000			
1 022	September 17, 200 2008. The survey fundamental surve of two clients were four females with vithe findings of this observations at the program, interview day program, reviered to include and investigation of the September 19, 20 throughout the fact damaged. Interview of two september 19, 20 throughout the fact damaged. Interview of two september 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged. Interview of the September 19, 20 throughout the fact damaged.	s survey were based of group home, one design to the group home one design of clinical and admitted facility's unusual imports.  MENTAL REQ / USE  I be supplied with curvich are kept clean, the met as evidenced be tion and interview, the nds and curtains at each of the company of the facility was observed to the with the House Material of the profession of 19, 2008 at appending the facility.	e sample sulation of lulation lul		All blinds have been by roller shades the facility.	replaced Unrughwut	ا ا <sup>۱</sup> ا
1135	i gougio fire oaf.	LII		' '			
_	Hatlan Administration  Matter  Monthson	IDER/SUPPLIER REPRESE	INTATIVE'S SIC	NATURE	Vice heidet	10//	(X8) DATE 1/08

STATE FORM

8000

.LZVC11

continuation Sheet 1 of 7

Health R	equiation Administra	ation			1	FURM	APPROVED
	r of deficiencies of correction	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		(X2) MULTII A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE 5 COMPL	ETED
WANE OF B	ROMDER OR SUPPLIER	HFD03-0172	STORET AND	DESC CITY S	TATE, ZIP CODE	09/1	9/2008
WHOLIS			1600 FRAI	NKLIN STRI TON, DC 20	EET, NE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
l 135	Continued From pa	ge 1		l 135		-	
·		l conduct simulated fi ectiveness of the plai ir for each shift.		-			
	Based on staff inter	met as evidenced by rview and record revi- ed to hold evacuation te.	ew, the				
	The finding include:	<b>s</b> :					
	Interview with the Qualified Mental Retardation Professional (QMRP) and review of the staffing pattern on September 18, 2008 at 11:56 AM revealed the scheduled shifts were as follows:				See w 159 w 440		
	Weekdays/Weeker	nds			W 770		
	1st Shift 8 AM to 4 2nd Shift 4 PM to 1 3rd Shift 12 AM to 1	2 AM					
•  - 	the staff were requiduring each shift. If August 2007 through 16, 2008 at 11;56 A failed to hold fire exthe first shift. Contacknowledged that conducted during e	ith the QMRP reveals ired to conduct a drill Review of the fire drill the August 2005 on SAM revealed that the vacuation drills quarts fire drills had not becard shift. There was rills were conducted	quarterly log from eptember facility arly during the QMRP an				
		uncorrected deficien ated August 22, 2007					

Health R	equiation Administra	tion					TITIO VED	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE (DENTIFICATION NUI HFD03-0172	RVCLIA MBER:	(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED	
NAME OF P	ROVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,	STREET AD	O9/19/2				
WHOLIS	_	·	1600 FRA	NKLIN STR ITON, DC 2	EET, NE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETE DATE	
1 208	Continued From pa	ge 2		1 206				
1 206	3509.6 PERSONNE	EL POLICIES		1206	,			
	annually thereafter, certification that a h performed and that	or to employment an shall provide a physi lealth inventory has b the employee's hes her to perform the re-	ician ' s leen alth status			,		
I 379	Based on Interview GHMRP failed to enhealth certificates of the finding Included Interview with the C Professional and reconducted on September of current health cethe time of the survice of the time of the survice of GHMRP shall health, Health Facilinusual incident or interferes with a resarrangement, well to places the resident be made by telephotollowed up by writting the state of the survice of the survive of the survi	s: Qualifed Mental Retar Eview of the personne ember 19, 2008 at 12 RP failed to provide e prtificates for one con-	dation of files 2:32 PM vidence sultant at 15519.5, nt of other tiglly are, living way tion shall be	379	All consultants cum have an updated p	Lastlag Nysical.	10/14/2	
	ntion Administration							

Health R	egulation Administra	ation			<del></del>	· · · · · · · · · · · · · · · · · · ·	<del></del>		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI HFD03-0172		(X2) MULTII A. BUILDING B. WING		(X3) DATE SU GOMPLET			
NAME OF PE	ROVIDER OR SUPPLIER	<del> </del>	STREET ADD	ADDRESS, CITY, STATE, ZIP CODE					
WHOLIST			1600 FRAI WASHING	NKLIN STRI TON, DC 20	EET, NE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Atement of Deficiencie Y Must be preceded by SC Identifying Inform	FULL !	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
1379	Based on interview GHMRP failed to e origin are reported and government at Regulation. [22 Display 10]  The finding include interview with the facility's incider corresponding investment 18, 200 following:  On May 29, 2008, transport Resident was exhibiting may potentially cause in Continued review to provide evidency to the Department 3520.3 PROFESS PROVISIONS  Professional serviand evaluation, indevelopmental leviservices, and services, and services.	met as evidenced by and record review, to and record review, to the facility's admired to the facility's admired to the Chapter 35 Section 15 Sec	ntal review of available alled the alled to t the time hat could thers. nts falled as reported d. NERAL h diagnosis of nent vent	1401	New Incident response measures have been been by propure the servey 7533 12th Street - Lin By August. Do. Shall be rotified by Main office about the followed we a phone cast to expense.	nursher at eccution H	10/1/28		
	This Statute is no Based on observe review, the GHMF	ot met as evidenced t ation, interview, and r RP failed to provide n as determined neces	ecord outine				 		

<u>Health R</u>	egulation Administra	ation '							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	r/CLIA VIBER:	A BUILDING	LE CONSTRUCTION	(X3) DATE SI COMPLE			
		HFD03-0172		B, WING		09/1	9/2008		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DORESS, CITY, STATE, ZIP CODE					
WHOLIST	FIC 08			NKLIN STRE TON, DC 20					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIE.  MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(XE) COMPLETE DATE		
1 401	Continued From pa	ige 4		I 401	1				
	the physician for or the sample. (Resid	ne of two residents in ent #1)	ciuded in						
	The finding include				,				
	was administered I mouth. Interview was prescribed for Review of Residen (POS) dated Septe 2008 at 1:18 PM reto receive Lithium I further record revifacility's Licensed I (LPN) on the same that Resident # 1's	2008 at 6:49 PM, Re Lithlum Carbonate 30 with the Trained Medi- evealed that the med maladaptive behavior it #1's Physician's Ordenber 2008 on Septe evealed an order for to levels every 2-3 moni- ew and interview with Practical Nurse Coorde day at 1:55 PM acking Lithium levels were in mended by the physician	oo mg by cation loation loation loss. The client the client control of the contro		w 325				
1 472	3522.3 MEDICATI	,		I <b>47</b> 2					
,	The physician who self-administration resident shall deve implementation.	identifies the of medications as a along and monitor the page and monito	goal for a plan for	,					
	Based on observation review, the GHMR	t met as evidenced b tions, interviews, and P falled to ensure the self-medication prog	record		see w371				
	The finding include	98:							
	See Federal Defic	lency Report Citation	W371			•			
1 500	3523.1 RESIDENT	T'S RIGHTS		i 600					
1			_						

Health Regulation Administration								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED				
<del></del>		HFD03-0172				09/*	9/2008	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
			NKLIN STRI TON, DC 2					
(X4) ID PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency must be preceded by full Regulatory or LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETE APPROPRIATE DATE			
1 500	Continued From page 5		1 500	<del></del>				
	that the rights of re- protected in accord	dence director shall e sidents are observed lance with D.C. Law : applicable District an	and 2-137, this		See W125		10/16/03	
	Based on observati Qualified Mental Re (QMRP) and record demonstrate how to protected and falled individual clients to of the facility, and a for 4 of 4 clients res	-	ie lel alled to were rage sa clients					
	The finding includes:							
,	protected by makin legally sanctioned r	ensure clients' right g certain each client representative to ass ons residential placer	had a ist them					
	17-19, 2008, a doo each time the exter Interview with the C Professional (QMR approximately 2;45 the door alarm was behavior of elopem that the use of the by the Human Righ of the HRC minutes September 19, 200 QMRP's statement		sound r opened. rdation , 2008 at rpose of l's target ther stated approved . Review on ned the		·			
'	Continued interviev	v with the QMRP rev	ealed that					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING	COMPLE	TED							
MEDAY-0477	V 3/ 1	(X3) DATE SURVEY COMPLETED 09/19/2008							
HFD03-0172		DI EUCO							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
WHOLISTIC 06 1600 FRANKLIN STREET, NE WASHINGTON, DC 20017									
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)								
1 500 Continued From page 6		,							
Client #4's housemates were informed of the and they all approved either by verbal response and/or by implication. The QMRP further revealed that Client #4's housemates legal guardians and/or involved family members were not involved in the decision making process regarding the door alarm.  Review of Client #4's housemates psychology assessments indicated that they did not evidence the capacity to make independent decisions on their behalf regarding habilitation planning, placement, treatment, financial or medical matters.									
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